THE Canadian Hospital

A Monthly Journal for Hospital Executives

Toronto, Can. **The Edwards Publishing Company** December, 1933

Food Quality for the Convalescent Child

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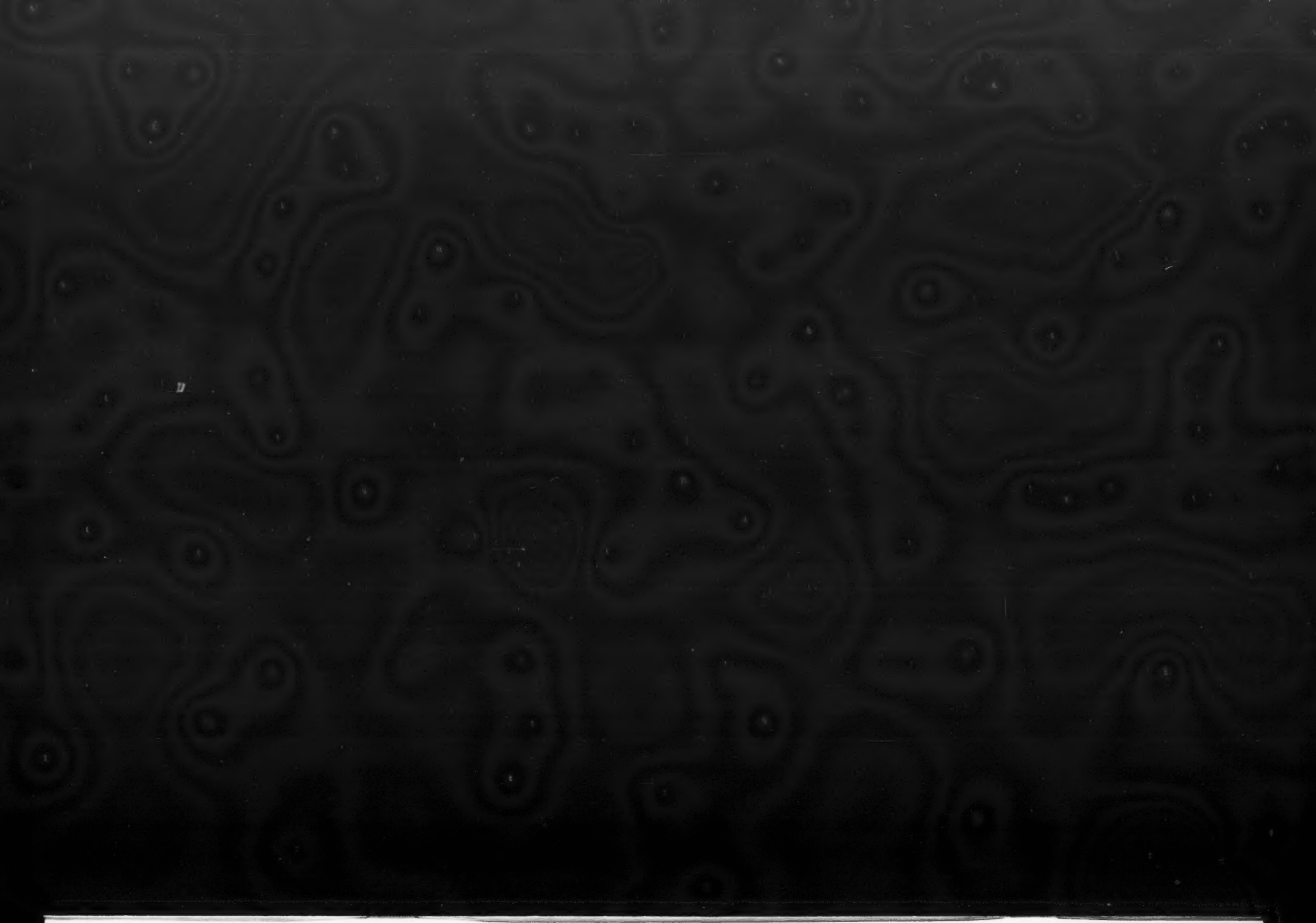

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How Hospitals Are Meeting Present-Day Conditions

By MALCOLM T. MacEACHERN, M.D., C.M., D.Sc., F.A.C.P.,
Associate Director, American College of Surgeons, and
Director of Hospital Activities

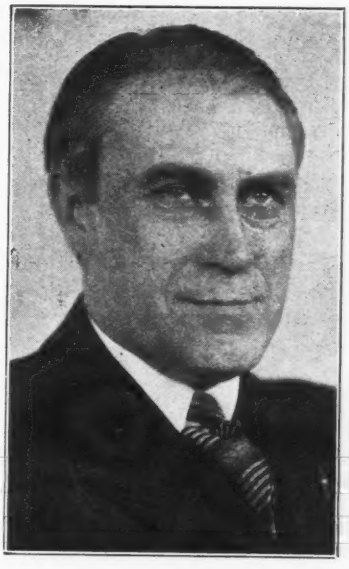
TO say that many of our hospitals to-day are facing serious financial difficulties is putting it mildly. For the past four years they have been trying to cope with a crucial situation. All institutions have been affected by serious economic conditions—and the hospital has not escaped. With endowments depreciated, donations and benefactions more or less paralyzed, earnings greatly diminished, and free work enormously increased, hospitals have been struggling courageously to maintain adequate standards in order to insure safe and efficient care of their patients. That they have succeeded at all is little short of miraculous. Indeed, our hospitals throughout Canada and the United States are worthy of especial commendation.

The courage and heroism of hospitals of Canada and the U.S. have been given a deserving tribute by the distinguished president of the University of Wisconsin, Glenn Frank, who said recently, when addressing the American Hospital Association at Milwaukee:

> Institutions as well as individuals can play heroic roles in difficult times. I think hospitals must be listed among the heroic institutions of this depression period, and for this heroism they pay a terrific price. They have made strict economy stricter; they have slashed salaries down the length of the payroll; they have heroically permitted deficits to pile up against some future day of reckoning; they have preferred to suffer a financial deficit rather than permit a service deficit; during the most trying years known to this generation, they have stood their ground; they have withheld nothing; they have not resorted to panicky, untimely, or hastily conceived appeals for financial help. We have had a bank holiday, but we have yet to hear of a hospital holiday. As we approach the turn of the economic tide, therefore, the hospitals stand as an heroic unit in the ranks of the community agencies that are seeing their towns or cities through to normal and better times; and the goodwill that hospitals have accumulated as a result of the institutional heroism they have displayed is to-day at a new high level on this continent.

Hospitals must now convert this goodwill into economic advantage. They are not commercial enterprises; they turn every dollar they receive to the care of the patient and other activities bearing on this worthy objective. They do not need money for selfish purposes; they need it for the efficient care of the patient.

Furthermore, hospitals themselves are an economic necessity. The efficient care of the sick is their first concern. But they are also important as educational institutions, in the advancement of scientific medicine and of clinical research, for the prevention of disease and the promotion of health. The financial value of the hospital to the public is far beyond human estimation.



M. T. MacEACHERN, M.D.

It is a great credit to the hospitals of Canada and of the United States that notwithstanding all these trying times there has been no moratorium declared on hospitals as a group or individually. In the United States, while one out of every 22 business organizations, and one out of every 6 banks were going into the hands of receivers, only one out of every 50 hospitals closed their doors, and these were in the main, small private institutions organized for profit, many of which never should have existed.

Hospitals must be maintained. The question is will they be able to continue in the face of present-day conditions? Fortunately, a good deal of consolation may be wrought from the oft-quoted phrase that even the worst of calamities may produce the finest of ultimate results. Certainly, never before in the history of hospitals have there been such careful analyses of hospital accounting and studies of financial policies. Repeated adjustments of expenses to income have been made; improvements in business methods have been inaugurated; more careful supervision of services has been effected. Hospitals have been working individually and collectively in order to weather the stormy economic disturbance. Somewhere in

An address presented at the Tenth Annual Convention of the Ontario Hospital Association, Toronto, October 26th, 1933.

the financial wreckage they will find a solid foundation upon which to build. Already, certain definite trends in hospital administration are evident which show how hospitals are attempting to meet present-day economic conditions.

Hospitals generally have put into effect drastic economies in their attempt to balance the budget.

So drastic have been some of the economies instituted by hospitals that accrediting organizations have sometimes had to issue warnings lest the service to the patient become imperiled. However, it may be truthfully said that the true balance between economies and efficient care of the patient has been well preserved throughout the hospital field during this period of economic adjustment.

The major efforts directed at reduction of expenditures and balancing of the budget have come from three main sources. In their order of effectiveness, these are, first: the more economical handling and use of foodstuffs and supplies; second, reduction in salaries and wages; third, reduction in personnel and readjustment of jobs or activities.

While there are no definite figures available as to the average aggregate reductions of expenditures in hospitals, many authorities make an estimate of from 15 to 20 per cent. I believe this is fairly conservative, and generally speaking, it has been the means of keeping many budgets nearly balanced.

The greatest economic adjustment made in hospitals has been in the handling and use of foodstuffs and supplies. This has been brought about through persistent study and increasing vigilance of these services. There have been developed better methods of accounting, and improved standards of distribution and consumption. Indeed, if you as a hospital administrator would make a hobby of assembling economy hints or suggestions that you initiate, that you observe elsewhere, that you hear discussed at meetings or that you read about, and if you would record these in a book appropriate for such a purpose, you would very shortly have a sizeable volume. For that reason, I have no time to go into such matters in detail.

The second effort to balance the budget has been made through the reduction of salaries and wages, averaging 12 to 15 per cent of the total payroll, with extremes from 2 to 40 per cent. Strange to say, but of great credit to our hospital personnel, a fine morale has been maintained notwithstanding salary reductions with their consequent hardship devolving upon many workers. Now, it is gratifying to learn that in some instances former salary and wage schedules are being restored, and I hope it will not be long before this can be universal in its application.

The third major source of expenditure reduction has arisen from reduction of personnel and readjustment of jobs or activities in hospitals. There has been effected an elimination of certain activities regarded as non-essential under present economic conditions, and an extensive combination of functions and activities under one person or service. In this manner reductions in personnel have been realized to a degree worthy of notice in many institutions.

Personally, I do not believe that reductions in personnel have always been warranted nor have all the readjustments of activities been wisely made or are they desirable, but in most instances they are impelled. To illustrate what I mean, permit me to mention two instances. The elimination of a competent dietitian in a large hospital and placing the food service under a steward, a cook, and a housekeeper, cannot be satisfactory, economical, or efficient. Imposing upon the superintendent a multitude of duties such as cooking, laundry and linen supervision, laboratory and X-ray technique, and administration of anesthesia in a 75-bed hospital, is not always economical, for we know that each of these activities could and should be performed by a lower-salaried individual. The superintendent should be free to administer the hospital as a whole rather than major or different units, some of which are minor in nature. But many desirable adjustments of services and activities and combinations have been made without in any way disturbing the quality of service.

We could profitably discuss the detail of these various measures directed at balancing the budget in hospitals, but time does not permit further comment. In my opinion, we have gone through a period of real and lasting valuable research into hospital management and administration, and from it we have gleaned information which has given us or will give us knowledge to recast some of our methods. My belief is that this will result in better business administration, improved standards of distribution and usage of hospital supplies, better organization of personnel and allocation of duties determined through a closer study of the work-load of the hospital. Eternal vigilance and frequent analyses of performance must go on regardless of whether times are good, bad, or indifferent. It may truly be said that there is no calamity but which brings in its wake some good.

Hospitals are choosing better trained and more adequately experienced persons for administrators.

You might well ask how the subject of trained and experienced administrators enters into a discussion of economies. The same question has been asked very often —in the past. But, to-day, the relation between capable administrators and sound financial conditions is not so frequently questioned. If the financial earthquake had uncovered nothing else of value, it would have still been important for revealing the extent of influence wielded by the hospital administrator. In altogether too many cases have men and women been given complete charge of institutions who were wholly untrained and entirely lacking in experience. The public as a whole has been prone to look upon the job of administering a hospital as a particularly easy task, something anyone can do, in fact. But the economic conditions during the past four years have been enough of a disturbance to jolt that fallacious idea, and show how directly proportionate are the financial stability and efficiency of a hospital to the training and experience of its administrator.

More and more is it being recognized to-day that the administration of the affairs of a modern hospital is no slight or trivial task. And it is being more clearly realized that much of the inefficiency and waste in hospitals can be traced directly to the inexperience of administrators. Hospitals generally are demanding that their superintendents be well trained, experienced, and skillful persons. They are advocating not only a complete university course in hospital administration for new people entering the field; they are also organizing short courses in post-graduate work for the large number of persons already

engaged in the hospital field. A good example is the Institute of Hospital Administration recently held in Chicago.

The importance of well trained and adequately experienced administrators for the sound and stable financial condition of a hospital and its efficient care of the sick and injured is to-day beyond dispute. There is no doubt but what superior administrators will mean superior hospitals.

Voluntary institutions are seeking the support of their governments for the care of their necessitous cases.

There has always been an unwritten code, a sort of tradition, that no patient requiring hospital care should be denied admission in any institution. The percentage of free work done in some hospitals to-day averages as high as 65 and 70 per cent. Certainly, this is far too heavy a burden, especially in these times. But the truth of the matter is that there are many tax-supported institutions which are not able to care for all the free or charity patients; hence, the burden has been thrust upon voluntary or non tax-supported hospitals in the community with little or no special financial support from any source other than much reduced earnings and meager donations or gifts.

The people of Canada and the United States have invested the sum of approximately $1,500,000,000 in tax-supported hospitals. Through taxation the public supports those governmental institutions with more than $415,000,000 each year. Voluntary hospitals have an investment of $1,404,000,000, almost as much as is invested in governmental institutions. Last year the voluntary hospitals cared for nearly 75 per cent of all patients who were given hospital care. In addition, more than one-third of this service was dedicated to the care of the free or necessitous patients. The income of the voluntary hospital has fallen off enormously during the past four years. Fewer and fewer patients are able to pay for any amount of their hospitalization. And charity patients who cannot get into the public, tax-supported hospital come to the voluntary institution for free care.

Certainly, then, non tax-supported institutions are perfectly reasonable in their belief that they should be reimbursed for the cost of the service which they are giving to such vast numbers of free patients, who cannot pay their way, and are, therefore, in actuality, charges of the state.

The voluntary hospitals of Canada have for many years enjoyed sympathetic though not always too liberal financial support from municipal and provincial governments in the care of their free patients. The policy of having such cases cared for in voluntary or community hospitals subsidized by municipal, provincial, or state governments without political control is commendable. Too often in tax-supported institutions where these patients are treated en masse is there political manipulation of appointments, and interference with the administration to the detriment of the care of the patient. Further, it costs the taxpayer more and robs the voluntary hospital of the volume of work required to absorb the necessary overhead which has to be maintained. In the United States, county hospitals for charity or necessitous patients are very common, particularly in the west and midwest. Consequently, there is very little or no financial support available from the municipality, county, or state for services rendered free or necessitous cases cared for by the non tax-supported institutions. In Chicago, for instance, in 1932 the voluntary hospitals did more free or charity work without any subsidy whatsoever from the city of Chicago or from Cook County than did the three tax-supported institutions in that city. In this same connection, Dr. Bert W. Caldwell, Executive Secretary of the American Hospital Association, addressing the opening session of the Sixteenth Annual Hospital Standardization Conference of the American College of Surgeons in Chicago two weeks ago, said:

> One-third of the work and service of these voluntary hospitals in 1932 was dedicated to the care of the charity patient. Out of 1,886,000 hospital days reported for 55 hospitals in the metropolitan area of Chicago, 411,726 were given to the care of charity patients for whose care no remuneration was expected nor received, and 362,000 days were given to the care of the patients of moderate means who paid the hospital less than 50 per cent of the cost of their care.

There has been a shift of patients from the voluntary or private hospital to the tax-supported hospital as well as from the pay wards to the charity wards of the voluntary hospital. The income of all hospitals has been greatly reduced whereas the expense of caring for the charity load has been greatly increased.

And, philanthropic income has vastly depreciated. Dr. Caldwell cites the following alarming figures which are a result of a careful survey of the hospitals of Canada and the United States. The income from all sources of philanthropy for hospitals between the years 1929 and 1932 was as follows:

1929-1930	$135,000,000
1930-1931	86,000,000
1931-1932	40,000,000

Figures are not available for 1933, but no doubt they will be further reduced. What, therefore, can hospitals do under these conditions? Is there not a great need for a more impressive awakening of the governmental bodies as to their respective community responsibilities for the care of the necessitous poor within their confines? In Canada you have made fine progress in this respect. In the United States much is yet to be done even to initiate the policy in many communities, and only a limited number of localities participate in such benefits.

I advocate the hospitalization of free or necessitous patients in approved voluntary or community hospitals cared for by competent, well organized medical staffs, where the cost of hospitalizing these patients is shared by the taxpayer and the philanthropist without political influence or manipulation of any kind. In this way millions of dollars can be saved the taxpayer in due course and the nation at large by not having to build, equip, and maintain huge tax-supported hospitals. We must lift the burden of paying for charity or free patients from the sick private patient, and place it where it properly belongs, that is on the consolidated revenues of the community and on philanthropy. It is good for the philanthropist to spend his money in so wholesome a manner, and it is good for our hospitals to still have that wholesome atmosphere of beneficiaries of philanthropy. This helps to keep our hospitals more human.

(To be concluded in January issue)

B.C. Hospitals Convention Deals With Many Pressing Problems

By RUTH M. THOMPSON

THE sixteenth annual convention of the British Columbia Hospitals Association was notably successful, with all sections of the province represented. Despite the widely scattered locations of the hospitals, the attendance from distant points is always good at this convention, largely due to the system of pooling travelling expenses. The programme featured many interesting papers and informal discussions; health insurance grants, problems of finance, "hitch hikers" and chiropractors were a few of the topics which aroused the most animated discussion.

President Coady struck the keynote of the convention in his presidential address by emphasizing the necessity of better financial support for hospitals. He reviewed the efforts of the association to influence the government not to institute the recent reductions in grants, and pointed out the handicap which this is proving to the hospitals. He reported that the Executive Committee was not hopeful that the meal tax would bring in very much revenue.

Mr. Charles F. McHardy of Nelson pointed out that many municipalities were receiving far more service from their hospitals than they were returning in financial aid. The opinion was freely expressed that some system of group insurance, either of a state nature or on a locally organized basis, would be found to be essential to solve the financial problem. A number of delegates reported the success of prepayment plans in their own communities.

In his report of the Winnipeg meeting of the Canadian Hospital Council, Mr. J. H. McVety emphasized the tremendous value of such a national body to the hospitals of Canada and urged the strongest support of its work.

In his luncheon address at the Royal Jubilee Hospital, Doctor Malcolm MacEachern, the guest speaker, said, "Hospitals are to-day instilling in the public a spirit of hospital-mindedness by evidencing among themselves a growing spirit of community-consciousness." In commenting on the courage and heroism of hospitals during these trying times he said that in the States, while one out of every twenty-two business organizations had gone into the hands of the receivers, only one out of fifty hospitals had closed their doors.

The question of whether or not hospitals should do X-ray work for chiropractors was raised. It was pointed out by several speakers that even though the hospital would give the X-ray plate to the chiropractor without diagnosis the hospital would be involved, in the public mind at least, in any misinterpretation which might result. It is generally accepted that the film should remain the property of the hospital, the interpretation being given to the medical practitioner, and such could not be done in the case of cultists without thus recognizing them. A further suggestion that cultists be barred from hospitals was not passed on to the resolution committee, not because of a desire on the part of delegates to permit the entry of such individuals to hospitals, as certain press dispatches would suggest, but because the demand for the admission of cultists to hospitals had not yet been seriously placed before hospitals.

In Doctor MacEachern's Round Table discussion centered on the following questions: "Has the depression strengthened the public demand for state medicine and hospital service?" "Flat rates including all services," "Periodic plan for the purchase of hospital care," "Educating the public in community service," "Results of hospital standardization," and "Are our hospitals meeting the needs of the people?"

The Sisters of St. Joseph were hosts at the Thursday luncheon, which was addressed by Dr. H. E. Young, Provincial Officer of Health.

Doctor Harvey Agnew of the Department of Hospital Service, Toronto, spoke on "Hospital Legislation in Canada." In his address, Dr. Agnew pointed out that while our legislation is far from Utopian and can stand much improvement, yet we should be grateful that in many respects our hospital legislation is better than in other countries. However, many revisions were pointed out as urgent. Arising out of Doctor Agnew's address a round table discussion took place dealing with the problems facing hospitals in the care of indigent transients moving from one province to another. Doctor Agnew said that with increased motor travel, particularly that "ubiquitous and demoralizing habit of hitch-hiking," these cases have become more numerous. In the Provinces of Manitoba, Saskatchewan and Alberta hospital legislation has made provision for the recognition of the accounts of hospitals in other provinces provided such other provinces pass similar legislation. Other topics discussed during the round table were: Sales Tax exemptions; traffic accidents and the responsibility of insurance companies; and legal liability of the hospital to the patient.

The final session was devoted to the subject of tuberculosis among nurses. Two very fine papers were presented to the convention, the first "Tuberculosis Among Nurses," by Dr. David A. Stewart, and the second by Dr. E. L. Ross, both of the Manitoba Sanatorium at Ninette. Dr. E. D. Lapp, superintendent of Tranquille Sanatorium; Dr. W. H. Hatfield of the Tuberculosis Clinic, V. G. H., Vancouver; Dr. A. S. Lamb, and Dr. M. T. MacEachern contributed to the discussion.

Resolutions adopted at the convention included demands for restoring provincial grants to the former level, an increase in municipal grants, a more satisfactory arrangement with the Workmen's Compensation Board, and a suggestion that legislation be sought making it obligatory for insurance companies to pay hospital accounts direct and to deduct the amount due the injured party from the policy.

Officers for the year 1933-34 are: Mr. J. M. Coady,

A group of delegates to the British Columbia Hospitals Association Convention, Empress Hotel, Victoria, November 8th to 10th, 1933.

re-elected President; Mr. E. S. Withers, New Westminister, 1st Vice-President; Mr. S. J. Drake, Victoria, 2nd Vice-President; Mr. J. H. McVety, re-elected Secretary-Treasurer.

Next year's convention will be held in Vancouver.

Queen Alexandra Sanatorium Patients Publish Magazine

The patients of the Queen Alexandra Sanatorium at Byron, Ontario, publish a very interesting and educational monthly magazine. A copy of the November issue, which has been sent to us, contains 24 pages and cover and deals with many timely subjects.

Dr. Crombie, Medical Superintendent, in dealing with a proposed Patients' Council of the Sanatorium, suggested a council of six men and six women patients to discuss with the Medical Superintendent matters of general interest, and especially to contact patient opinion.

The Sanatorium, striving always to supply its patients with the best in pure foods, recently opened its own pasteurizing plant where the milk from their own fully accredited and government inspected herd is made even more safe through pasteurizing in an ultra-modern and spotlessly clean dairy. A specially constructed building and the most modern equipment has been provided by the Sanatorium for this purpose.

I.O.D.E. Preventorium Makes Splendid Record During Year

The I.O.D.E. Preventorium at Toronto closed a successful year on November 16th with the annual meeting held at the institution. $591,000 is the total value of funds and property according to the report of the treasurer, Mrs. John Bruce. The endowment fund amounts to $116,844, and the emergency maintenance reserve fund, $149,166, with the general maintenance fund, including grants owing from the municipal and provincial governments reaching $32,936. The property account has reached $291,931, announced the treasurer.

Col. A. E. Gooderham presided over the meeting, with Dr. F. G. Fitzgerald, dean of the faculty of medicine, Toronto University, as speaker of the occasion. As the meeting closed, a dramatic touch was the singing of "Land of Hope and Glory" by a choir of the Preventorium children, massed in the corridor.

Excellent reports were presented by the officers. It was interesting to note that more money had been spent this year on milk than on drugs and medicines, a new feature of the Preventorium work. 290 children were admitted to the institution during the year, with the total number in residence being 395. The average stay at the hospital for a patient was 104 days and the average number of meals served monthly, 15,190.

Intelligent Purchasing and Control of Supplies is Based on Detailed Knowledge

By S. T. MARTIN,
Assistant Superintendent, Regina General Hospital.

WHEN dealing with this subject, one must realize that all procedures laid down will not be applicable to all hospitals alike. The plan suitable for a 400 bed, or larger hospital, would not be workable in an institution, say of 20 beds. Yet there are certain business principles which can be used in all hospitals, no matter of what capacity.

This question can best be dealt with by discussing each of the following component parts separately:

1. The purchase itself.
2. Receiving and storing the goods purchased.
3. Issuance.
4. The records relating to the purchase and issuance.

MR. S. T. MARTIN

1. PURCHASING in all institutions should be centralized. That is, one person should be responsible. In the larger institutions, where there is an assistant superintendent, this work is usually delegated to his office as a primary duty. In the smaller institutions, without an assistant, the purchasing should be done by the superintendent, or at least he or she should closely scrutinize and sign all purchase orders. Judicious expenditure of the hospital's money can only be carried out by a person who has an intimate and sympathetic understanding of the financial condition of the hospital. One of the fundamental principles of business that can be adopted is that the consumer should never purchase, or have control, of the issuance of the goods he handles.

Purchasing, on no matter how large or small a scale, should be done only on a competitive basis, quality being the first, and price and service the second consideration. This competitive buying may be taken care of in various ways, and will depend more or less on the available sources of supply.

In the larger centres where the greater part of your supplies can be obtained locally, much competitive buying can be done by obtaining prices over the telephone. Fresh meats, fresh fruits and vegetables can be purchased in this way. Monthly quotations are usually called for on such items as groceries, milk and dairy products, printing, etc. On items such as gauze and cotton, on which the usual protected time against decline or increase in price by the Canadian jobber is three months, no object is to be gained by purchasing for a longer period. Coal is an item that is usually tendered for on a yearly basis.

In the smaller communities, where sources of supply are more limited, competitive buying would still be in order. In many cases, where the hospital is situated at some distance from the jobbers, it will be necessary to obtain prices from the salesman who calls from time to time, and file them for future use in buying.

In some communities again, co-operative buying or buying through hospital purchasing bureaus, where organized, has shown a marked saving in purchases, particularly for the smaller institutions.

All purchases should be planned—that is, each department budgeted, and an estimate quantity determined of all goods to be used. This is of inestimable value to the one making the purchases. One writer in discussing this question, very ably brings out the three essentials of good purchasing, "Know your Needs," "Buy only what you need," and "Make sure you get what you ordered."

Purchases should be so arranged that immediate needs are always protected, and that replacements arrive or are ordered in an orderly manner. In these days of rapid transportation and immediate deliveries, there is little necessity to buy for the future, with the resultant outlay of money, warehousing, depreciation by age, dirt and frequent handling, as well as the tendency to consume greater quantities when the supply is abundant.

Standardization is another phase of purchasing which will show big returns. The average hospital uses too many styles and sizes of most of the multitude of articles which make up its purchases. Many of the items, for example, glassware, enamel ware, dishes, hypodermic needles, bedding, plumbing and electric fixtures, can be reduced to a few patterns and sizes without any inconvenience to any of the services. This makes for better purchasing, since the stock is easier to maintain and control, and better price for a larger quantity of one size rather than a smaller quantity of a greater number of sizes. Standardization is a question that hospital administrators should make a more serious effort to put into effect. In the modern hospital there is no place for the personal preferences or the idiosyncrasies of the many individuals making up the staff of the hospital. It is too costly.

Owing to frequent changes in technique, or to the change in style or pattern of many items, the item in use is returned to the stores, and with the stock on hand becomes obsolete. Before the purchase of any new line is

made, the stock on hand should be used up, either for the purpose for which it was purchased, or for some substituted use.

Since hospitals, in their daily operation, make use of most commodities that enter into our present social scheme, the purchasing agent for such supplies must have a knowledge of all the major items purchased, and he must have a knowledge of not only local, but world market conditions in such lines as rubber, cotton, etc., and other such information that will assist him in deciding to buy or not to buy seasonable or other items.

In larger hospitals, because the purchasing is supervised usually by the assistant superintendent, who has other administrative duties to perform, certain hours are set aside for the receiving of salesmen. Every representative who calls should be interviewed, as much information can be gained from the representative of a reputable house, who knows his goods. It is from such persons that the buyer must gain not only a good deal of his knowledge about the goods themselves, but also about the market conditions of the same items. Salesmen should not be allowed to call on the various department heads, and any contact between the department head and the salesman should be made in the Purchasing Office. However, just because a salesman has been interviewed, it does not follow that goods were purchased. A good buyer will anticipate his wants, and for this reason should be in very close contact with the stores and know at all times what the consumption is on the goods he is required to purchase.

Close co-operation between the various department heads must be maintained, if the purchasing is to be to the best advantage of the hospital, and frequent or daily contact must be the order.

Lastly, no goods should be purchased without the issuing of a signed purchase order, setting out the quantity, the quality, the full terms of purchase and whether F.O.B. the hospital or the shipping point. This form should be at least in triplicate—the original going to the firm from which the purchase is made, the duplicate filed in the purchase office as a record, and the triplicate going to the stores to be checked against, when the goods are received.

2. RECEIVING AND STORAGE. Here again is a very valuable department that it is advisable to have centralized and the responsibility placed upon one person, (usually the storekeeper). The department should be so aranged that all business is transacted at the counter, and doors and other openings arranged so as to preclude "leaks."

Goods as received should be checked for quantity and quality against the purchase order copy. Whether the original invoice or a "goods received" slip is made out and used is immaterial. Any shortage, breakage, etc., should be notated and the record sent to the purchase office for attention.

The stores should be of sufficient size and so arranged that all merchandise is easily accessible, and not tucked away in dark corners to deteriorate or be overlooked. Provisions should be stored in such a manner as to be kept free from vermin. For convenience, the various

(Continued on page 26)

Consider Many Phases of Hospital Economics at Saskatchewan Convention

THE Saskatchewan Hospital Association, which met recently in Saskatoon, accomplished much in furthering hospital progress in the prairie province, and reflected a great deal of credit on the capable president, Mr. Leonard Shaw. Preceding the meeting, stimulating bulletins were sent to all members urging them to make every effort to attend, and the enthusiastic gatherings were most gratifying. During the two-day session consideration of financial problems, hospital management and group health insurance plans occupied much of the programme.

The convention took place the week preceding the British Columbia meeting in order to allow Doctor MacEachern and Dr. Agnew to attend both conventions. Unfortunately Dr. MacEachern could not be present, but his assignments were capable handled by Dr. Agnew, along with his own. Dr. Agnew's report on "The Canadian Hospital Council—What it Has Done and Can Do for You," was followed by a general discussion on Canadian hospital problems and a round table discussion on various questions of particular interest.

Mr. Shaw, in his presidential address, reviewed the previous year's work and spoke of meetings which officials of the hospital and medical organizations held with the government and of the progress made. He also asked the meeting to consider an invitation from Alberta and Manitoba hospital authorities to hold a joint convention periodically, so that their work and viewpoint will be broadened.

Joint Convention of Western Associations Suggested

The programme contained many valuable papers, of which we mention, "Transmission of Schools of Nursing to Graduate Staff," read by Miss C. E. Guillod of Maple Creek; "General Management of a Hospital with Graduate Staff," by Mrs. Helen Frazier of Hafford; "Doctors, Hospitals and Patients," by Dr. H. E. Alexander, St. Paul's Hospital, Saskatoon, and "Rural Indigent Problem," by Mr. S. R. Curtin, K.C.

On two occasions the meeting was divided into small groups to discuss urban problems, led by Dr. H. H. Mitchell of Regina; "Small Hospital Problems," under Mr. J. McQueen of Yorkton; "Union Hospital Problems," led by Mr. A. Esson of Rosetown, and "Nursing," under Miss E. Amos.

An interesting feature was the paper read by Mrs. D. Rannard on the work of the Saskatoon City Junior Club. This club was formed a year ago on the suggestion of Doctor MacEachern and has had a very successful year.

The Hon. F. D. Munro, Minister of Health, and Doctor Harvey Agnew, spoke at the Annual Banquet, after which the guests had the privilege of viewing Doctor MacEachern's film "Good Hospital Care," as well as an interesting amateur film of the Century of Progress Exposition, taken by Mr. Shaw during his recent visit to Chicago.

SUTURES IN ANCIENT SURGERY

HEINRICH von PFOLSPEUNDT was a knight of the Teutonic Order and his experience in wound surgery was gained during the wars with Poland. His was the first surgical treatise written in German (1460), was the first to describe gun-shot wounds, and shows an insistance on cleanliness far in advance of his time He used sutures sparingly in the treatment of wounds but when necessary inserted a few interrupted sutures of green silk passed deeply through the tissues and tied over a quill or silver tube.

Kalmerid Catgut

EMBODIES all the essentials of the perfect suture. Being impregnated with the double iodine compound, potassium-mercuric-iodide, it exerts a bactericidal action in the suture tract and supersedes the older unstable iodized catgut. Prepared in two varieties—Non-Boilable for those desiring the maximum of suture flexibility, and Boilable for those preferring to sterilize the exterior of tubes by boiling or autoclaving. Both varieties are heat sterilized.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH
1405	PLAIN CATGUT	*approx.* 5′
1425	10-DAY CHROMIC	" 5′
1445	20-DAY CHROMIC	" 5′
1485	40-DAY CHROMIC	" 5′

BOILABLE VARIETY

1205	PLAIN CATGUT	*approx.* 5′
1225	10-DAY CHROMIC	" 5′
1245	20-DAY CHROMIC	" 5′
1285	40-DAY CHROMIC	" 5′

Sizes: 000 . . 00 . . 0 . . 1 . . 2 . . 3 . . 4
also 4-0 in non-boilable variety

Package of 12 tubes of a kind $3.60

Kal-dermic Skin Sutures

A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.

NO.		SUTURE LENGTH	DOZEN
550	WITHOUT NEEDLE	120″	$3.60
954	WITH ½-CURVED NEEDLE	20″	3.00

Sizes: 000 (FINE) 00 (MEDIUM) 0 (COARSE)

852	WITHOUT NEEDLE	40″	1.80

Sizes: 8-0 . . 6-0 . . 4-0 . . 000 . . 00 . . 0

In packages of 12 tubes of a kind and size

Kal-dermic Tension Sutures

IDENTICAL in all respects to Kal-dermic skin sutures but larger in size.

NO.		SUTURE LENGTH	DOZEN
555	WITHOUT NEEDLE	60″	$3.60
855	WITHOUT NEEDLE	20″	1.80

Sizes: 1 (FINE) 2 (MEDIUM) 3 (COARSE)

In packages of 12 tubes of a kind and size

Intestinal Sutures

KALMERID plain or chromic catgut with Atraumatic needles integrally affixed. For gastro-intestinal work and membranes where minimized trauma is desired.

EXCEPTIONAL STRENGTH HERE

NON-BOILABLE VARIETY

Plain Catgut:

NO.		SUTURE LENGTH	DOZEN
1501	STRAIGHT NEEDLE	28″	$3.60
1503	⅜-CIRCLE NEEDLE	28″	4.20
1504	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1505	½-CIRCLE NEEDLE	28″	4.20

20-*Day Chromic:*

1541	STRAIGHT NEEDLE	28″	$3.60
1542	TWO STRAIGHT NEEDLES	36″	4.20
1543	⅜-CIRCLE NEEDLE	28″	4.20
1544	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1545	½-CIRCLE NEEDLE	28″	4.20

BOILABLE VARIETY

Plain Catgut:

1301	STRAIGHT NEEDLE	28″	$3.60
1303	⅜-CIRCLE NEEDLE	28″	4.20
1304	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1305	½-CIRCLE NEEDLE	28″	4 20

20-*Day Chromic:*

1341	STRAIGHT NEEDLE	28″	$3.60
1342	TWO STRAIGHT NEEDLES	36″	4.20
1343	⅜-CIRCLE NEEDLE	28″	4.20
1344	SMALL ½-CIRCLE NEEDLE*	28″	4.20
1345	½-CIRCLE NEEDLE	28″	4.20

Sizes: 00 . . 0 . . 1, except *00 . . 0 only

In packages of 12 tubes of a kind and size

Circumcision Sutures

KALMERID plain catgut threaded on a small, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
630	WITH EYED NEEDLE	28″	00, 0
635	WITH ATRAUMATIC NEEDLE	28″	00, 0

BOILABLE VARIETY

600	WITH EYED NEEDLE	28″	00, 0
605	WITH ATRAUMATIC NEEDLE	28″	00, 0

Package of 4 tubes $1.20; per doz. $3.60

DISCOUNTS ON QUANTITIES

DAVIS & GECK, INC. ▫ 217 DUFFIELD ST. ▫ BROOKLYN, N.Y.

D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

Obstetrical Sutures

KALMERID 40-day catgut threaded on a large, full-curved eyed needle, or with an Atraumatic needle integrally affixed.

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
680	With Eyed Needle	28″	2, 3
685	With Atraumatic Needle	28″	2, 3

BOILABLE VARIETY

650	With Eyed Needle	28″	2, 3
655	With Atraumatic Needle	28″	2, 3

Package of 3 tubes $1.20; per doz. $4.20

Special Purpose Sutures

WITH Atraumatic needles integrally affixed. Selection of needles and material based on consensus of professional opinion. Suture length 18 inches. Boilable.

Plastic Sutures:

NO.	MATERIAL	SIZE	NEEDLE SHAPE	LENGTH
1651	Kal-dermic	6-0	3/8-Circle	5/8″
1655	Kal-dermic	4-0	1/2-Curved	7/8″
1658	Black Silk	4-0	1/2-Curved	7/8″

Eye Sutures:

1661	Black Silk	6-0	1/2-Circle	3/4″
1665	Black Silk	4-0	3/8-Circle	5/8″
1666	Plain Catgut	3-0	3/8-Circle*	1/2″
1667	Plain Catgut	3-0	3/8-Circle	1/2″
1668	10-Day Catgut	3-0	3/8-Circle*	5/8″
1669	10-Day Catgut	3-0	3/8-Circle	5/8″

* Double armed, suture length 12 inches

Nerve Sutures:

1670	Black Silk	6-0	Straight	3/8″

Artery Sutures:

1675	Black Silk	6-0	Straight	3/4″
1678	Black Silk	6-0	1/2-Circle	3/4″

Package of 12 tubes of a kind $4.20

Tonsil Sutures

KALMERID plain catgut with a 1¼ inch half-circle Atraumatic needle of correct diameter affixed. Suture length 28 inches.

NO.		SIZE
1605	Boilable Variety	0
1615	Non-Boilable Variety	0

Package of 12 tubes $4.20

Ribbon Gut

AN absorbable ribbon of animal intestinal tissue for nephrotomy wound closure by the Lowsley-Bishop technic. Ribbon length, 18 inches. Boilable.

NO.		WIDTH
20	Plain	5/8″

Package of 12 tubes $3.60

Short Sutures for Minor Surgery

NON-BOILABLE VARIETY

NO.		SUTURE LENGTH	SIZES
702	Plain Kalmerid Catgut	20″	00 to 3
722	20-Day Kalmerid "	20″	00 to 3
742	40-Day Kalmerid "	20″	00 to 3

BOILABLE VARIETY

802	Plain Kalmerid Catgut	20″	00 to 3
812	10-Day Kalmerid "	20″	00 to 3
822	20-Day Kalmerid "	20″	00 to 3
842	40-Day Kalmerid "	20″	00 to 3
862	Horsehair	56″	00
872	White Silkworm Gut	28″	0
882	White Twisted Silk	20″	000, 0, 2
892	Umbilical Tape	24″	1/8″ wide

Package of 12 tubes of a kind $1.80

Emergency Sutures

THREADED on half-curved eyed needles with cutting edges for skin, muscle, or tendon. Boilable.

NO.		SUTURE LENGTH	SIZES
904	Plain Kalmerid Catgut	20″	00 to 3
914	10-Day Kalmerid "	20″	00 to 3
924	20-Day Kalmerid "	20″	00 to 3
964	Horsehair	56″	00
974	White Silkworm Gut	28″	0
984	White Twisted Silk	20″	000, 0, 2

In packages of 12 tubes of a kind

Emergency Suture Assortment:

900 . . Assorted—Catgut, Silk, and Kal-dermic Skin Sutures, on half-curved needles

Package of 12 tubes $3.00

Other D&G Products

INFORMATION and prices covering silk, kangaroo tendons, horsehair, celluloid-linen, umbilical tape in jars, and Kalmerid germicidal tablets will be sent upon request.

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Vincent Massey Heads Drive for Anglican Hospital

One of the strongest organizations ever to undertake a public campaign in Toronto has been completed under the general chairmanship of Hon. Vincent Massey to raise $300,000 by public subscription for the new Sisters of St. John the Divine Convalescent Hospital campaign.

The campaign will open Dec. 9 and will be carried on until Dec. 16.

Organized in 1884, the Anglican Sisterhood has conducted philanthropies during the past half-century so quietly that they have remained almost in obscurity. It has never appealed to the public at large for financial assistance, private and intimate friends having supplied whatever funds were necessary for the extensive charities carried on.

Finding it necessary for so large a project, the Sisterhood has decided now to bring the convalescent hospital enterprise before the public.

A large group of the most influential men in the city have accepted posts at the head of the organization. To assist them a full size regiment of energetic and successful men has been formed among the professions and business circles.

Hastings Memorial Hospital Adds to Toronto's Facilities

The comparatively new but now vacant hospital building adjacent to the Riverdale Isolation Hospital on St. Matthews Road, Toronto, was christened the Hastings Memorial Hospital by the local board of health on November 8th, and ordered utilized for a trial period of one year as a separate institution for the care of indigent sufferers from incurable diseases.

The name chosen for the establishment commemorates the late Dr. C. J. O. Hastings, who won world-wide fame during the many years he was Toronto's medical officer of health.

The first patients in the building, which was built six or seven years ago, but has been little used since diphtheria and other epidemics subsided, will be indigent incurables now being maintained by the city in the Hospital for Incurables. The advisory committee on hospitalization, which recommended to the health board the use of the one-time isolation building, reported that the provincial Government had advised the city the rate for maintenance of these patients would have to be increased from $1.50 to $2 a day if they were not removed by the city to some other institution.

Dr. J. G. Fitzgerald Goes to India

Dr. J. G. Fitzgerald, Dean of Medicine, University of Toronto, and director of the School of Hygiene and of the Connaught Laboratories, has been selected by the Rockefeller Foundation as a member of a committee to conduct a health survey of India, according to an announcement made recently. It was stated that Dr. Fitzgerald will leave on his mission in December. He is also a member of the health committee of the League of Nations, from whose meeting at Geneva he returned a few weeks ago.

THE Canadian Hospital

Published in the interests of Hospital Executives

ISSUED ON THE SEVENTH
OF EVERY MONTH BY

THE EDWARDS PUBLISHING COMPANY
177 JARVIS STREET
TORONTO 2 - CANADA

C. A. EDWARDS - - Managing Editor

TELEPHONE ADELAIDE 9684

Subscription Price $2.00

Authorized by the Post Office Department as Second Class Matter.

Vol. 10 DECEMBER, 1933 No. 11

Report of Canadian Hospital Council Will Soon Be Available

FOR the past two years the committees of the Canadian Hospital Council have been preparing reports on various hospital topics and it is hoped these will be available to hospitals and organizations about the first of the year. These reports formed the basis of deliberation at the recent meeting in Winnipeg and contain what is probably the finest review of the hospital situation throughout Canada which has yet been compiled. One of the most valuable is the report on Construction and Equipment, which is a compilation of a number of studies comprising sections on operating room lighting, insulation, dietary department, psychopathic annexes, etc. For the past four years there has been very little activity in the construction of hospitals and this report offers many helpful suggestions for any hospitals considering renovating old buildings, expanding their present ones or modernizing the equipment.

The report on Public Relations includes an analysis of the way in which our present hospital facilities are meeting the needs of the people in Canada and points out our lack of accommodation for such classes of patients as convalescents, early mental or incurable patients and those suffering from chronic or communicable diseases.

An interesting study of medical relationship was included in the report on "Relations between the Medical Staff and the Hospital."

In view of the present state of hospital accountancy the report on Finance should be of real value. In its report, the finance committee, in an effort to overcome the non-uniform state of hospital statistics, recommends the formation of a committee of statisticians, accountants, hospital executives and government representatives to compile accounting standards for each class of hospital standards which would eventually become obligatory throughout Canada.

The committee report on Administration and Statistics deals also with accountancy in hospitals and, among other matters, recommends the establishment of uniform standards for estimating patient day costs.

The Small Hospital report is an unusually comprehensive study of the problems of our smaller institutions. Problems of management, segregation, and isolation of patients, laundry, visitors and purchasing are but a few of the topics embodied in the report.

The report on Legislation contains a very fine comparative analysis of legislation in the different provinces. This should prove a valuable guide in making comparisons of legislative precedures in the various provinces.

A very valuable study has been prepared on Tuberculosis in Nurses by the Committee on Research, but as this will require at least four to five years, it is not likely that the present report will be published.

What Are You Doing to Further the Christmas Spirit?

NOW is the time to make preparations for the Festive Season. If there is one day in the year when the hospital dietitian can excel—that day is Christmas. It is the custom for many hospitals to plan a special menu and at the appearance of the breakfast tray on which a tiny clothes pin Santa Claus bears a cheery greeting card, the feeling of homesickness is at least mitigated. Appropriate Christmas favours could be placed on the patients' trays beginning with Christmas eve and extending through supper on Christmas day.

Be sure that no one is overlooked. If it can be arranged for every patient to receive a remembrance then Christmas will be Christmas indeed. In many hospitals this service is performed by women of the community, who are delighted to be able to bring joy to those who are forced to spend this season away from home.

Christmas trees could be placed in wards and nurses' homes, in front hall and in the clinic and table trees could be arranged at several vantage points. Some hospitals provide an annual entertainment for the dispensary patients and the various women's organizations could take this opportunity of planning a gaily decorated tree and dispensing warm clothing to the needy.

Employees should not be forgotten, and if funds do not permit of money gifts something in the nature of a Christmas banquet or entertainment could be planned for the staff and their families, and those who remain on duty Christmas day could be released on New Year's Day as an alternative.

Christmas Day brings its quota of visitors and regulations governing visiting hours should not be too strictly enforced.

Additional means of bringing Christmas to the hospital might include a "movie" provided by one of the friends of the hospital, Christmas carols sung by church choirs, and radio programmes which feature Christmas music.

The Golden Age of Quackery Takes Heavy Toll

IN a recent address "Quacks Versus Science" Doctor Herbert A. Bruce, Lieutenant-Governor of Ontario, exposed the many frauds practised upon the women of to-day. He said "There is more money made by quacks to-day than at any other time in the history of medicine." Declaring there is no such thing as skin "food," Doctor Bruce endeavoured to show the grave danger of the subtle propaganda and the misleading advertisements which aroused false hope in the hearts of sufferers and all other anti-social activities of quacks who prey on a gullible public by offering worthless remedies.

Referring to the victimization of women, His Honour said, "Surely the Roman lady who centuries ago applied beauty aids made from burnt bear claws, lizard tallow and extract of crocodile, hoping for wonderful results from this mixture was no more optimistic than the modern woman who believes she can 'feed' the skin by rubbing in fats or creams of any kind."

Maintaining that the modern quack prospers by committing wild buffooneries in the name of science, Doctor Bruce said, "Until the public wakes up he will continue to prosper and he would be the envy of all the quacks of earlier times were they able to visualize the 20th century as the golden age of quackery." Doctor Bruce then mentioned a few of the types of healing to-day offered to the public and said it is a mockery of our civilization when it is possible for men and women of seeming intelligence to entrust their health and their very lives to men totally ignorant of the structure of the human body, its functions and the nature of the diseases they profess to cure. "The secrecy which quacks maintain as to the ingredients of their nostrums is in itself their greatest condemnation," said Doctor Bruce. "It should cause intelligent people to suspect their values. It is only dishonesty that fears the light. All the great scientific discoveries which have made possible the care of hitherto fatal diseases have been given freely to the world without cost."

We are indeed fortunate in having in public office a man who strikes out so vigourously in protecting the public health and in defence of those who have been so habitually preyed upon by mercenary interests. So often when a man gets into public office he says nice little speeches that are timely and appropriate, but mean very little, and it is indeed refreshing to have in office a man like Doctor Bruce, who in his recent utterances has also shown his sympathetic interest in racial welfare and in obtaining more extensive convalescent facilities in this country.

Should Our Hospitals Be Above Politics?

RECENT press despatches refer to the dismissal of the superintendent of nurses at the Nova Scotia Sanatorium at Kentville, following the provisional election held a few weeks ago. This dismissal made good news for the press because of the fact that Miss Allen

(Continued on page 25)

News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, and Personal News of Hospital Workers

BRANTFORD, ONT.—Miss A. E. Bingeman, superintendent of the Freeport Sanatorium, was elected chairman of districts Nos. 2 and 3 of the Registered Nurses' Association of Ontario, at the annual meeting held here in November. Other officers chosen were: Vice-chairman, Miss H. L. Potts, superintendent of the Woodstock Hospital; secretary-treasurer, Miss E. M. Jones, Brantford; councillors, Miss K. Charnley, Brantford; Miss M. McCorkindale, Goderich; Miss H. Dennis, Guelph: Miss A. G. Cook, Woodstock; Miss F. Kudoba, Stratford; Miss E. Seely, Kitchener; representative of nurse education section, Miss R. M. Hamilton, Stratford; public health representative, Miss E. Eby, Guelph; private duty, Miss M. Davidson, Woodstock.

* * *

CHARLOTTETOWN, P.E.I. — The trustees of King's County Hospital have purchased the land and buildings formerly occupied by the Royal Hotel, and will use the property, after making alterations, for hospital purposes. The main building has 22 rooms, and will accommodate 10 beds.

* * *

CLARESHOLM, ALBERTA.—The new mental hospital at Claresholm was completed in October, and is now being occupied.

The building is a frame structure, with concrete walls and hardwood floors, with the exception of the basement, which is tiled.

The change in appearance of the inside of the building, formerly the school of agriculture, is due chiefly to the new partition walls, and stair guards.

The hospital property comprises 160 acres and the buildings are surrounded by trees and a profusion of flowers. Particular care will be taken to have the grounds beautified again to insure the patients of pleasant surroundings.

* * *

GUELPH, ONT.—Dr. Harry Borden, well-known young Guelph physician, has received the appointment as Assistant Superintendent of Saint John County Hospital, Saint John, N.B. Dr. Borden, a graduate of the University of Toronto Faculty of Medicine, has been house surgeon at St. Joseph's Hospital, and previous to graduation last year was intern at St. Michael's Hospital, Toronto, and later at the Hamilton General Hospital.

* * *

MONTREAL, QUE.—The names of six Montrealers, who have been added to the board of management of the Verdun Protestant Hospital as directors, were announced in October by Hon. Walter Mitchell, K.C., president of the board. The new directors are: Col. Herbert Molson, C.M.G., M.C.; Hon. Gordon W. Scott, M.L.C.; John C. Newman, chairman of the Harbour Commission of Montreal; Dr. Charles F. Martin, dean of the faculty of medicine, McGill University; Dr. Wilder G. Penfield, head of the Neurological Institute, and Dr. F. H. Mackay.

* * *

NORTH BATTLEFORD, SASK.—The public service commission has issued a list of the candidates who were successful at the recent examination for the position of male attendants at the provincial mental hospitals at Weyburn and Battleford.

Of 256 persons who qualified under the rules to take the examination, 212 actually wrote it, 138 passed and 74 failed. The type of candidate was exceptionally high. Among those who took part were university graduates, teachers, students of medicine, pharmacy, theology and accountancy.

OWEN SOUND, ONT.—For the first time in many years the Owen Sound General and Marine Hospital through the inspiration and direction of the superintendent, Miss Bert. M. Hall, R.N., has solved the problem of a comfortable, bright and restful home for its nursing staff. Recently completed after months of arduous work and planning, the entire south wing of the hospital has been renovated and furnished anew on its entire three floors as a residence for its nursing staff, which at the present time, since the addition last month of ten probationers, numbers nearly forty. The old nurses' home at the entrance to the hospital grounds, which for many years proved inadequate for the housing of the nurses, is vacant and the entire hospital staff is now under one roof.

* * *

REVELSTOKE, B.C.—Miss Etta Hodgson, R.N., of Vernon, a graduate of the Queen Victoria Hospital Nursing School, was appointed night supervisor in succession to Miss McDonald, resigned, at the last meeting of the Queen Victoria Hospital Board.

The change was effective December 1st.

* * *

THREE RIVERS, ONT.—Dr. C. E. Cross, of Normand-Cross Hospital, was elected president of the Three Rivers Medical Society at a general meeting held here in October. Vice-presidents are: Dr. Joseph Garceau, Shawinigan Falls, Que., and Dr. Auguste Panneton, Three Rivers. Dr. Joseph Normand was appointed secretary-treasurer.

* * *

TORONTO.—Miss Helen Le Vescente, who for the past five years has been chief aide at the Ontario Hospital, Kingston, has been appointed to the staff of the Psychiatric Hospital, Toronto.

* * *

TORONTO.—Hon. Dr. J. M. Robb has announced that the provincial government will make provision for further expansion at Mimico Hospital, where, it is hoped, 135 beds will be added this winter, and within the next twelve months his department hopes to have an institution there which will accommodate 1,000 patients.

* * *

TORONTO.—City hospitals provide a total accommodation of 3,190 beds. City Clerk J. W. Somers told city council on October 30th. Of the 2,081 beds in public wards, 140 were reported as vacant. In semi-private wards, 144 beds were vacant out of a total accommodation of 582 beds.

* * *

TORONTO.—Owing to the congestion which has developed in the free clinics due to the growing demand for medical services in the city, St. Mary's Hospital, 550 Jarvis Street, has announced the opening of a free clinic which will be in operation every Tuesday morning at nine o'clock.

The free clinic will deal with treatments for the ear, nose and throat, and particular attention will be given to tonsils operations. The free clinic will only be available on Tuesday mornings for the present, so it was announced.

(Continued on next page)

News of Hospitals and Staffs

(Continued from preceding page)

TORONTO.—On Monday, November 6th, the X-ray and urological services of the Toronto General Hospital were moved from the present quarters in the Flavelle wing of the main building to the Dunlap building, north of the private patients' pavilion, on University Ave.

In utilizing the new building, the trustees of the hospital will virtually complete the hospital buildings as they have been visualized ever since rebuilding was decided on in 1925. It was the munifiicent bequest of the late David A. Dunlap that enabled this final transfer to be made.

* * *

TORONTO.—History is repeating itself following the auction sales of the effects at the old Arlington Hotel, corner of King St. W. and John St., traditional home of visiting show folk. Up to 1854 Toronto's first general hospital stood on this site. After the sale the property was handed over as a gift, and unencumbered, to the Toronto General Hospital, by its owner, A. C. Budd. After more than three-quarters of a century it returns to its original owners.

The old Arlington Hotel came into being from a group of brick buildings, erected about 1868, after the first general hospital was torn down.

The old general hospital that stood on this site was used by the legislature from 1824 to 1828, after the burning of the parliament buildings.

* * *

WINDSOR, ONT.—Windsor City Council went on record on November 13th, as favoring construction of a $200,000 addition to the Hotel Dieu Hospital as an unemployment relief project. The consent of the Ontario Government is now sought.

Ontario Experimenting With Health Services

In preparation for the advent, if necessary, of state dentistry or medicine, or hospitalization or all combined, the province of Ontario is now, and has been for the last year, conducting a study of five eastern countries for the purpose of being fully armed with knowledge of the operation of public services along state controlled lines, Hon. Dr. J. M.Robb, Minister of Public Health, told the annual banquet of the Academy of Dentistry of Toronto at the Royal York Hotel on October 23rd.

Dr. Robb intimated that the Department of Public Health regarded of immediate importance the need of some new scheme of caring for the public's health, and suggested that some such scheme as now exists in the employment of teachers might be found equally efficient for state medicine.

"In five eastern countries we are experimenting along public health lines—not state medicine—but a study along these lines in the fields of medicine, dentistry and hospitalization," he said. "If we are to be faced with some new scheme of looking after the health of the public we can face it with at least a degree of knowledge.

"I don't know whether state dentistry is here or not, or if state medicine is here or not, but if it is then I think it is a good thing to be prepared, to be in a position where we can give our views."

Hospital Aid News

What the Hospital Can Do for the Mother

ALL that has been said so far on the subject of Hospital Care, and all that will be said, takes something for granted, something which is the foundation of good Hospital care — *The Spirit of the Hospital.*

There are few in this audience who have not heard of the name and fame of Miss Mary Agnes Snively, of Toronto General Hospital, the Mother of the Nursing Profession in this Province and in this country, who recently went to her rest full of years and full of honours. How often Miss Snively used to say:—"I think my Nurses are kind." That was one of her ideals.

It was not in vain that on the lintel of the door of the "Old General" on Gerrard Street, that these words were carved in the stone: *"I was sick and ye visited me."*

Stone and building have passed away. Mr. Justice Patterson, then Chairman of the Hospital Trust, to whom we probably owe that inscription in that place, passed away long years ago. Miss Snively herself, almost the last survivor of the "Old Guard" at the "Old General" has gone to her reward. But the spirit remains. And if you would find it, go to the Pre-Natal Clinic in the present General Hospital.

There you will find an atmosphere of kindness. To establish and carry on such a clinic is one of the greatest things that the hospital can do for the mother. Nothing helps more to save the life and health of mother and child than pre-natal care. The clinic may almost be said to be the key to the situation for it finds out what is needed, and it can get these needs attended to whether the mother is to be confined in her home or in the hospital. It was not by chance that the convener of the Toronto Board of Health Maternal Welfare Sub-Committees, Dr. W. B. Hendry, Professor of Obstetrics and Gynaecology in the Medical Faculty of the University of Toronto, is also Chief of this hospital maternity service, including the pre-natal clinic. His self-denying labours, ably seconded by his colleagues on the committee, and not least by Miss Thompson, of the Maternal and Child Welfare Division in the Municipal Department of Health, and his genius for co-operation, have given us this highly valuable report.

The mother, when she comes to this pre-natal clinic, finds a comfortable place prepared for her and a nurse to assist her. After she has seen the doctor he points to another door and says—"Go in there, the nurse has something for you." "In there" — she gets a cup of tea and a biscuit. If you get one of the mothers to tell you about this pre-natal clinic, she may forget to tell you about some of the things the doctor says, but she never forgets to tell you about the cup of tea and the biscuit that the hospital gave her. It is a friendly gesture and the mother

Part of an address by Dr. Helen MacMurchy, Chief of the Division of Child Welfare, Department of Pensions and National Health, at the Annual Meeting of the Women's Hospital Aids Association, Royal York Hotel, Toronto, October 26th, 1933.

What the Hospital Can Do for the Mother

(Continued from preceding page)

understands it. It helps to interpret to her the ideal of hospital service.

Hospital pre-natal clinics and post-natal clinics, of course, are not perfect. Even the maternity wards are not perfect. They should all teach the mother more, especially the simple things, like diet, and making baby clothes and making all the preparations. Some mothers need help with House Management and Care of Children. Clinics should have, and most of them do have, a simple mother's text-book to give away, and the nurse should go over this text-book with the mother and explain it all to her and make sure she can do these simple things. Before she leaves the maternity ward, the mother should understand well all the details of nursing the baby at her breast, and bathing and dressing the baby.

This teaching is another great thing that the hospital can do for the mother. "No opportunity of making useful suggestions should be lost." We must see the mother through and finish our work, and provide some way that afterwards, when the mother is at home again, she will have someone to help her in her difficulties. The hospital post-natal clinic and the well-baby clinic would seem to be the natural places to organize this education of the mother, and this remark applies as much to the mother whose baby was born at home as the mother whose baby was born in the hospital.

The organization of all these clinics need to be developed. It is not possible for any nurse to visit often enough the home of every mother coming to the clinic. A good plan is being tried in another Canadian city. The mothers are divided into little groups. Begin with the primiparae. Get ten or twelve of them to come at a certain hour on a certain day during the winter. Arrange study classes or lecture classes for them and go over the whole question of the care of children. The doctor and nurse might take alternate weeks. The nurse could make sure that the mothers understand all the doctor taught them the week before. It seems a satisfactory plan. We might try it.

Often the mother needs encouragement. She is doing nobly but there is no one to tell her so, to cheer her on her way and to re-assure her.

We should not forget the unmarried mother. The hospital and its staff can do a great deal for her. The Hospital Social Service Staff, with their knowledge of community resources, may well be her best friend and advisers and helpers. She needs help so much to recover her character and her self-respect and her standing in the community. We can help her and we can get others to help her.

As the report already referred to says plainly, the abnormal case should be cared for in the hospital. If there is anything wrong or likely to go wrong, the hospital is the place for the mother. Emergencies are part of the regular hospital day's work. A good hospital is ready for every emergency. Skill, knowledge, experience, and all the apparatus and materials needed are there ready at hand at a moment's notice, and at every moment, day or night, someone is near who can see what is needed and

get it at once. If, for example, birth is impending before the due time, then the hospital is the place where the mother and baby are safest and best cared for, with the best chance that the premature baby will live.

Under present circumstances when the income of the father is so much reduced, sometimes almost to the vanishing point, many of our hospitals are making special efforts to help in this emergency. One hospital has announced a rate of $17.00 for ten days' hospital care for maternity patients and their babies. Other hospitals are making almost equal reductions. So that another thing our hospitals are doing just now for the mother and her family is to reduce the expense of maternity care.

Physio-therapy is a wonderful benefit. It restores the mother's strength and her good figure and posture. Most of our hospitals now have physiotherapists on the staff, and the mothers in the public wards get the benefit without extra expense. We might have an address on this subject next year.

Hospital care, with its quietness, and its good organization, is a great protection to the mother. For a suitable period "No Visitors" are admitted to see her. The mother does not always get this protection in the home. Visitors sometimes get into the home and disturb the mother. Visitors cannot get into the hospital if the doctor or the head nurse says "No."

Dr. W. H. Dickson, Famous Radiologist, Dies

At his late residence, 58 Lympstone Avenue, Lawrence Park, Toronto, there occurred on October 28th the death of W. Howard Dickson, M.D., C.M., F.R.C.P. (Canada), member of the Royal Society of Canada.

Dr. Dickson, a foremost figure for the past ten years as a radiologist and diagnostician, had recently gained widespread recognition on the publication of the results of his research work with thorium dioxide.

Dr. Dickson was a native of Pembroke, Ont., only son of the late Dr. William Welland Dickson of that town. After graduation from McGill University in 1904, Dr. Dickson spent several years in general practice in Western Canada, being in charge of medical services for the Granby Mining and Smelting Company with headquarters at Vancouver and operating hospitals at Phoenix and Anyox, British Columbia.

Realizing early the importance of X-ray in diagnosis, Dr. Dickson, after considerable private study and experiment, joined the clinic of Dr. Lewis Gregory Cole, eminent radiologist of New York City, where he spent two years.

Dr. Dickson returned to Canada fifteen years ago and became a member of the staff of the Toronto General Hospital and of the teaching staff of the University of Toronto. Since that time he had been closely engaged in active practice, to which of late years he had joined research. He was known as one of the best diagnosticians on the continent in gastro-intestinal X-ray work. His development of the use of thorium dioxide for more accurate X-ray diagnosis was one of the great recent advances in medicine. A mass of detailed material had been gathered by Dr. Dickson for publication of a book embodying much of his life-work, which his untimely death at the age of 55 has cut short.

Dr. Dickson was a member of the York Club, the Royal Canadian Yacht Club and of the Aesculapian Club of Canada. He is survived by the widow and two daughters, Dorothy and Evelyn, and three sisters, Mrs. A. T. Mackie of Toronto and Mrs. W. H. Williams and Miss Ada D. Dickson of Pembroke.

Should Our Hospitals Be Above Politics?

(Continued from page 19)

was the first Canadian nurse to enlist for overseas service and had been decorated by the King for service during the war.

The alleged charges were that Miss Allen "had acted in a partisan manner politically," during the recent provincial campaign. It is unfortunate that this situation has arisen, for it cannot but give a feeling of insecurity to those holding professional or other appointments in government or municipal institutions, of which hospitals the number is steadily increasing.

We are not in a position to pass any comment upon the rights or wrongs of the situation. However, it is obvious that those holding governmental or municipal positions are not in a position to take sides or to be expected to take sides in any political controversy no matter what their personal inclination may be. This is one of the problems which may be expected should voluntary direction of hospitals be superseded by extensive municipal or other public ownership.

The following comment from a Montreal paper would seem of interest:

"To-day Premier Angus L. Macdonald made public a letter that he had written to Miss Allen in which he declared that the Government did not have power to refer the matter to the Supreme Court. 'So far as this government is concerned,' he said, 'the matter is considered definitely closed'."

Intelligent Purchasing and Control of Supplies is Based on Detailed Knowledge

(Continued from page 11)

types of supplies should be segregated. (The only exception to centralized stores might be the dispensary stock, and the drums of iodine, alcohol, glycerine, etc., to which the dispensary requires daily access, should be turned over to the dispensary stores.) The writer does not favor the use of bins or drawers, as they are difficult to keep clean, they harbour vermin and make excellent storage places for obsolete stock, or stock which will become obsolete. Rather, all shelving should be made moveable, and where it is necessary to keep such stock as stationery, linen, etc., free from dust, the shelves may be provided with doors, but everything should be arranged so that the control of vermin is made possible.

3. ISSUANCE. While undoubtedly much money can be saved for an institution by good buying, it is in distribution that the hospital has a potentiality of greater saving than in any other phase of operation.

The secret of economy in distribution is control of the requisition. A requisition is simply a request for certain goods, and the final decision as to the necessity for or the hospital's financial ability to issue the goods, must rest with the superintendent and his assistants. Any thought in the supervision of the requisition is not from the desire to prevent any one, or any service, from having a necessary supply, but solely to eliminate waste, which precludes the possibility of having desired as against essential supplies.

Requisitions for supplies, that is, consumable supplies, should be made out on a proper form and signed by the department head, but before being presented to the stores, should be checked and authorized by the superintendent, his assistant or the superintendent of nurses, the only exception to this being the dietitian's requisitions for food products. All replacements for defective or broken equipment should be entirely on an exchange basis, the defective article to be returned to the stores before a new article is issued. For the orderly conduct of the exchange, one day a week should be set aside for this, and one of the executive heads should go over the returned articles to settle as to which article should be repaired for further service, and which exchanged for a new one.

For the control of requisitions and for the better conduct of the stores, it is necessary to have a weekly requisition day. All the departments should send in their requisitions for a week's supply of the various items they require, the only exception to this being for emergency supplies, which when the requisition has been properly authorized, are taken care of at all times. By the issuing of supplies in reasonable quantities, large stocks are not accumulated on the wards. The proper place for stock to be kept is in the stores.

4. RECORDS. The system of records necessary for the proper conduct of the purchase and stores department will depend again upon the size of the hospital, the staff available for this purpose and the use to be made of the records kept.

Definite data should be accumulated, either by card index systems or loose-leaf ledgers, as to the quantities purchased, the date and price, as well as the final disposition of the goods bought. As to the system being used as a perpetual inventory, this again depends on the manner of issuance. For instance, it would be impossible to use a card system where each requisition was debited against the stock showing on the inventory. If such an item as bread, which is in daily use, was sent to say 20 stations, on 20 requisitions, the total of the day's requisitions of this item would be charged as one entry, rather than 20 individual entries. This applies to the great majority of broken package items. However, it is desirable to work out a method of inventory which will answer your institution's needs. That is, show the purchase and the final disposition of the item. The system should be such that too many adjusting entries are not necessary. It is advisable that these records be combined into one record, that is, the purchase, disposal of and the balance on hand. This record can be kept by the storekeeper or, as is usual where a central office is maintained, by the purchase office.

Without this information, scientific buying is impossible and the control of your stock must be left to guess work.

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